		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040741

Facility Name: DEERBROOK CARE CENTRE

Address: 306 NORTH LARKIN AVE. (Number) JOLIET (City) 60435 (Zip Code)

County: WILL

Telephone Number: (815) 744-5560 **Fax #** (815) 744-6914

IDPA ID Number: 36-3943427001

Date of Initial License for Current Owners: 04/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	217	Skilled (SNF)	217	79,205	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	217	TOTALS	217	79,205	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,609	1,165	8,110	14,884	8
9	SNF/PED					9
10	ICF	39,196	8,134	1,992	49,322	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,805	9,299	10,102	64,206	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.06%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 211 and days of care provided 5,034

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	221,192	24,116	12,684	257,992		257,992	(625)	257,367			1
2	Food Purchase		239,822		239,822		239,822	(1,933)	237,889			2
3	Housekeeping	200,274	39,478	0	239,752		239,752	(206)	239,546			3
4	Laundry	89,357	27,825	51	117,233		117,233	(1,357)	115,876			4
5	Heat and Other Utilities			159,451	159,451		159,451	0	159,451			5
6	Maintenance	57,729	45,696	35,412	138,837		138,837	(286)	138,551			6
7	Other (specify):*			9,337	9,337		9,337	0	9,337			7
8	**TOTAL General Services**	568,552	376,937	216,935	1,162,424	0	1,162,424	(4,407)	1,158,017			8
	B. Health Care and Programs											
9	Medical Director	0		6,000	6,000		6,000	0	6,000			9
10	Nursing and Medical Records	2,299,950	151,348	43,908	2,495,206		2,495,206	5,238	2,500,444			10
10a	Therapy	0		0	0		0	0	0			10a
11	Activities	116,266	17,109	286	133,661		133,661	1,149	134,810			11
12	Social Services	32,637		663	33,300		33,300	0	33,300			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			530	530		530	0	530			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	2,448,853	168,457	51,387	2,668,697	0	2,668,697	6,387	2,675,084			16
	C. General Administration											
17	Administrative	368,137		699,442	1,067,579		1,067,579	(674,928)	392,651			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			211,434	211,434		211,434	10,698	222,132			19
20	Dues, Fees, Subscriptions & Promotions			186,540	186,540		186,540	(147,772)	38,768			20
21	Clerical & General Office Expenses	254,123	51,763	51,936	357,822		357,822	134,959	492,781			21
22	Employee Benefits & Payroll Taxes			617,539	617,539		617,539	0	617,539			22
23	Inservice Training & Education			9,524	9,524		9,524	0	9,524			23
24	Travel and Seminar			1,632	1,632		1,632	12,520	14,152			24
25	Other Admin. Staff Transportation			8,411	8,411		8,411	0	8,411			25
26	Insurance-Prop.Liab.Malpractice			15,499	15,499		15,499	165,283	180,782			26
27	Other (specify):*			47,053	47,053		47,053	(47,053)	0			27
28	**TOTAL General Administration**	622,260	51,763	1,849,010	2,523,033	0	2,523,033	(546,293)	1,976,740			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,639,665	597,157	2,117,332	6,354,154	0	6,354,154	(544,313)	5,809,841			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number DEERBROOK CARE CENTRE #0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			72,699	72,699		72,699	208,464	281,163			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			115,530	115,530		115,530	231,057	346,587			32
33	Real Estate Taxes			83,807	83,807		83,807	0	83,807			33
34	Rent-Facility & Grounds			930,086	930,086		930,086	(921,089)	8,997			34
35	Rent-Equipment & Vehicles			49,347	49,347		49,347	8,098	57,445			35
36	Other (specify):* STORAGE			1,667	1,667		1,667	0	1,667			36
37	**TOTAL Ownership**			1,253,136	1,253,136	0	1,253,136	(473,470)	779,666			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		286,032	226,282	512,314		512,314	0	512,314			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			118,807	118,807		118,807	0	118,807			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	286,032	345,089	631,121	0	631,121	0	631,121			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,639,665	883,189	3,715,557	8,238,411	0	8,238,411	(1,017,783)	7,220,628			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(22,942)	30		9
10	Interest and Other Investment Income	(115,530)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,933)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(197)	21		18
19	Entertainment	(76,796)	20		19
20	Contributions	(6,580)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(2,569)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47,053)	27		24
25	Fund Raising, Advertising and Promotional	(56,375)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(10,286)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(6,007)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (346,268)		$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(671,515)	PG6&6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (671,515)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,017,783)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

DEERBROOK CARE CENTRE

ID# 0040741

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 55	6	1
2	VACATION ACCRUAL	(625)	1	2
3	VACATION ACCRUAL	(206)	3	3
4	VACATION ACCRUAL	(1,357)	4	4
5	VACATION ACCRUAL	(341)	6	5
6	VACATION ACCRUAL	(6,578)	10	6
7	VACATION ACCRUAL	1,149	11	7
8	VACATION ACCRUAL	6,247	17	8
9	VACATION ACCRUAL	(4,351)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(6,007)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(625)	0	0	0	0	0	0	0	0	0	0	(625)	1
2	Food Purchase	(1,933)	0	0	0	0	0	0	0	0	0	0	(1,933)	2
3	Housekeeping	(206)	0	0	0	0	0	0	0	0	0	0	(206)	3
4	Laundry	(1,357)	0	0	0	0	0	0	0	0	0	0	(1,357)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(286)	0	0	0	0	0	0	0	0	0	0	(286)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,407)	0	0	0	0	0	0	0	0	0	0	(4,407)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(6,578)	11,816	0	0	0	0	0	0	0	0	0	5,238	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	1,149	0	0	0	0	0	0	0	0	0	0	1,149	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(5,429)	11,816	0	0	0	0	0	0	0	0	0	6,387	16
	C. General Administration													
17	Administrative	6,247	(681,175)	0	0	0	0	0	0	0	0	0	(674,928)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,569)	5,811	7,456	0	0	0	0	0	0	0	0	10,698	19
20	Fees, Subscriptions & Promotions	(150,037)	2,265	0	0	0	0	0	0	0	0	0	(147,772)	20
21	Clerical & General Office Expenses	(4,548)	139,507	0	0	0	0	0	0	0	0	0	134,959	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,520	0	0	0	0	0	0	0	0	0	12,520	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	4,020	161,263	0	0	0	0	0	0	0	0	165,283	26
27	Other (specify):*	(47,053)	0	0	0	0	0	0	0	0	0	0	(47,053)	27
28	TOTAL General Administration	(197,960)	(517,052)	168,719	0	0	0	0	0	0	0	0	(546,293)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(207,796)	(505,236)	168,719	0	0	0	0	0	0	0	0	(544,313)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(22,942)	6,434	224,972	0	0	0	0	0	0	0	0	208,464	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(115,530)	0	346,587	0	0	0	0	0	0	0	0	231,057	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,997	(930,086)	0	0	0	0	0	0	0	0	(921,089)	34
35	Rent-Equipment & Vehicles	0	8,098	0	0	0	0	0	0	0	0	0	8,098	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(138,472)	23,529	(358,527)	0	0	0	0	0	0	0	0	(473,470)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(346,268)	(481,707)	(189,808)	0	0	0	0	0	0	0	0	(1,017,783)	45

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD.		MANAGEMENT/
OWNERS		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					ROSEMONT	
				DEERBROOK NURSING CENTRE		
					ROSEMONT	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 11,816	$ 11,816	1
2	V	17	ADMINISTRATIVE	699,442	MR. BELLOWS OWNS 19% OF THIS FACILITY		18,267	(681,175)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		5,811	5,811	3
4	V	20	DUES & SUBSCRIPTIONS		" "		2,265	2,265	4
5	V	21	CLERICAL		" "		139,507	139,507	5
6	V	24	TRAVEL		" "		12,520	12,520	6
7	V	26	INSURANCE		" "		4,020	4,020	7
8	V	30	DEPRECIATION		" "		6,434	6,434	8
9	V	34	RENT		" "		8,997	8,997	9
10	V	35	RENT-EQUIPMENT & VEH		" "		8,098	8,098	10
11	V								11
12	V								12
13	V								13
14	Total			$ 699,442			$ 217,735	$ * (481,707)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 930,086	DEERBROOK NURSING CENTRE		$	$ (930,086)	15
16	V	19	ACCOUNTING FEES		" "		7,725	7,725	16
17	V	19	LEGAL FEES		" "		(269)	(269)	17
18	V	26	GENERAL INSURANCE		" "		138,036	138,036	18
19	V	26	MORTGAGE INSURANCE		" "		23,227	23,227	19
20	V	30	DEPRECIATION-BLDG & IMP		" "		213,319	213,319	20
21	V	30	DEPRECIATION - EQUIP & FURN.		" "		11,653	11,653	21
22	V	32	AMORTIZATION - MTG COST		" "		3,136	3,136	22
23	V	32	MORTGAGE INTEREST		" "		343,451	343,451	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 930,086			$ 740,278	$ * (189,808)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	0.19	SEE ATTACHED	2.46	13.00	SALARY	18,267	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 18,267		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 10700 W. HIGGINS ROAD, STE. 300
City / State / Zip Code: ROSEMONT, IL 60018
Phone Number: (847) 296-9625
Fax Number: (847) 298-0824

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	501,904	10	$ 92,369	$ 92,369	64,206	$ 11,816	1
2	17	ADMINISTRATIVE	PATIENT DAYS	501,904	10	140,817	140,817	64,206	18,267	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	501,904	10	44,800		64,206	5,811	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	501,904	10	17,462		64,206	2,265	4
5	21	CLERICAL	PATIENT DAYS	501,904	10	130,659		64,206	16,715	5
6	21	CLERICAL	DIRECT COST	1	1	122,792	122,792	1	122,792	6
7	24	TRAVEL	PATIENT DAYS	501,904	10	96,528		64,206	12,520	7
8	26	INSURANCE	PATIENT DAYS	501,904	10	30,995		64,206	4,020	8
9	30	DEPRECIATION	PATIENT DAYS	501,904	10	49,603		64,206	6,434	9
10	34	RENT	PATIENT DAYS	501,904	10	69,364		64,206	8,997	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	501,904	10	62,438		64,206	8,098	11
12										12
13										13
14								139,276		14
15								231		15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 857,827	$ 355,978		$ 217,735	25

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - DEERBROOK NURSING HOME						$	$			$	1
2	GMAC		X	MORTGAGE	$31,776.00	09/97	4,775,900	4,634,528	09/32	7.3750	343,451	2
3	GMAC		X	LOAN COST	AMORT-35YRS		109,773	96,184			3,136	3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BNK		X	WORKING CAPITAL			416,200	1,415,000	VARIES	PRIME+	110,661	6
7	CRESTWOOD HEIGHTS	X		WORKING CAPITAL			50,000	59,230	DEMAND	0.0850	4,810	7
8	FIRST HEALTHCARE	X		WORKING CAPITAL			27,063	1,239	DEMAND	PRIME+	59	8
9	TOTAL Facility Related				$31,776.00		$ 5,378,936	$ 6,206,181			$ 462,117	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 5,378,936	$ 6,206,181			$ 462,117	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 76,764	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 79,847	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,083	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 80,724	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 83,807	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	67,164	8
	1997	72,146	9
	1998	72,376	10
	1999	75,926	11
	2000	79,847	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DEERBROOK CARE CENTRE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0040741

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-07-401-034-0000	NURSING HOME	$ 79,847.00	$ 79,847.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 79,847.00	$ 79,847.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,380 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	105,000	1975	$ 247,500	1
2	754 BASIS ADJ.		1992	13,220	2
3	TOTALS	105,000		$ 260,720	3

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	217			1975	$ 1,849,704	$ 29,750	35	$ 52,849	$ 23,099	$ 1,386,209	4
5				1980	168,687	0	20	0		168,687	5
6	754 ADJ			1992	125,584	3,987	31.5	3,987		37,878	6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - DEERBROOK NURSING CENTRE										9
10	IMPROVEMENTS			1984	33,823	1,691	20	1,691		29,592	10
11	IMPROVEMENTS			1986	21,535	1,120	20	1,077	(43)	16,693	11
12	IMPROVEMENTS			1987	78,860	2,504	20	3,943	1,439	57,619	12
13	IMPROVEMENTS			1988	48,614	1,544	31.5	1,544		20,500	13
14	IMPROVEMENTS			1989	60,430	1,919	31.5	1,919		24,768	14
15	IMPROVEMENTS			1990	30,485	967	3.5	967		10,776	15
16	IMPROVEMENTS			1991	53,134	1,688	31.5	1,688		17,592	16
17	IMPROVEMENTS			1992	117,363	3,725	31.5	3,725		34,764	17
18	IMPROVEMENTS			1993	29,335	932	39	932		8,239	18
19	IMPROVEMENTS			1993	29,864	767	27.5	767		6,392	19
20	IMPROVEMENTS			1994	37,711	1,371	27.5	1,371		10,037	20
21	VINYL SLIDER UNITS			1995	3,070	112	27.5	112		723	21
22	DOORS			1995	2,564	93	27.5	93		601	22
23	ROOF			1996	24,069	875	27.5	875		4,849	23
24	OUR TOWN			1996	74,400	2,705	27.5	2,705		13,638	24
25	ROOF/REMODEL KITCHEN/DUMPSTER/FLOORS			1997	448,432	16,305	27.5	16,305		70,433	25
26	ALZHEIMERS WING CONSTRUCTION			1997	1,590,575	57,833	27.5	57,833		250,053	26
27	OUR TOWN			1998	21,500	782	27.5	782		3,095	27
28	ALZHEIMERS WING CONSTRUCTION-FINAL DRAW			1998	17,009	618	27.5	618		2,447	28
29	DINING ROOM FLOOR - TILES			1998	30,000	1,091	27.5	1,091		4,319	29
30	DOOR ALARM SYSTEMS			1998	24,760	900	27.5	900		3,563	30
31	SPRINKLERS			1998	3,500	127	27.5	127		503	31
32	DINING ROOM - WALLPAPER/TILE BASE			1998	14,900	542	27.5	542		2,100	32
33	RENOVATE 2 ROOMS/REPLACE ELEVATOR FLOORS			1998	9,400	342	27.5	342		1,297	33
34	REMODELING OF ELEVATOR - LOBBY			1998	7,050	256	27.5	256		950	34
35	LANDSCAPING			1998	2,815	102	27.5	102		379	35
36	ROOF TO PTAC UNITS			1998	3,508	128	27.5	128		474	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DINING & RESIDENT ROOM FLOORS	1998	$ 15,268	$ 555	27.5	$ 555	$	$ 2,012	37
38	HOT WATER TANK	1998	1,780	65	27.5	65		235	38
39	REMODELING - SHOWER ROOM	1998	3,830	139	27.5	139		469	39
40	ASPHALT PARKING LOT & SPEED BUMPS	1998	17,156	624	27.5	624		2,002	40
41	WALLCOVERING/WINDOW TRMTS/TILES	1998	18,635	678	27.5	678		2,175	41
42	REMODELING - RESIDENT ROOMS	1998	37,050	1,347	27.5	1,347		4,096	42
43	WINDOW TREATMENTS/ REMODEL RMS	1999	18,066	657	27.5	657		1,944	43
44	FIRE ALARM & HVAC/CEILING/HALLS/CALL LIGHTS	1999	25,000	909	27.5	909		2,614	44
45	REPAIR & REMODEL HALLWAY/DOOR MONITOR SYS	1999	23,425	852	27.5	852		2,378	45
46	REMODEL ROOMS/DOOR MONITOR SYS	1999	45,989	1,672	27.5	1,672		4,529	46
47	REMODEL RMS/LANDSCAPING	1999	53,572	1,948	27.5	1,948		5,114	47
48	WALLCOVERING/WINDOW TRMTS/TILES	1999	6,950	253	27.5	253		643	48
49	REMODELING RMS	1999	16,205	589	27.5	589		1,448	49
50	WALLCOVERING/FLOOR TILES/HANDRAILS	1999	28,464	1,035	27.5	1,035		2,458	50
51	REMODELING RMS	1999	47,115	1,713	27.5	1,713		3,926	51
52	NURSE STATION/ELEVATOR DOORS	1999	18,030	656	27.5	656		1,449	52
53	RMODELING ROOMS/WINDOW TRMTS	1999	170,712	6,207	27.5	6,207		12,673	53
54	FIRE DAMPERS	2000	4,950	180	27.5	180		353	54
55	REMODELING-WASHROOMS/MEDICAL REC. RM	2000	35,550	1,293	27.5	1,293		2,316	55
56	FENCES	2000	3,557	129	27.5	129		221	56
57	WALLCOVERING/WINDOW TRMTS-RES & DINING RMS	2000	69,939	2,543	27.5	2,543		3,921	57
58	FIREWALL/RESIDENT ROOM CEILINGS/TUCKPOINTING	2000	85,160	3,096	27.5	3,096		4,774	58
59	MAGNETIC DOOR/STEAMER	2000	16,334	451	27.5	451		773	59
60	HANDRAILS	2000	8,101	295	27.5	295		430	60
61	REMODELING - NURSE STATION/CORRIDOR/DINING RM	2000	126,731	4,608	27.5	4,608		6,721	61
62	PTAC UNITS	2000	3,550	129	27.5	129		188	62
63	CONCRETE PAVING	2000	11,700	425	27.5	425		620	63
64	IRRIGATION SYSTEM & ROOM PLATES	2000	10,425	379	27.5	379		521	64
65	DESIGN & BUILD ENABLING GARDEN	2000	19,832	1,323	15	1,323		1,983	65
66	CARPETING/WINDOW TREATMENT	2000	14,549	529	27.5	529		683	66
67	PTAC UNITS	2000	3,550	129	27.5	129		167	67
68	REMODELING - BREAK ROOM, MEDICATION RM	2000	39,886	1,450	27.5	1,450		1,873	68
69	SIDEWALK	2000	2,240	81	27.5	81		98	69
70	TOTAL (lines 4 thru 69)		$ 5,965,982	$ 171,715		$ 196,210	$ 24,495	$ 2,264,977	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,965,982	$ 171,715		$ 196,210	$ 24,495	$ 2,264,977	1
2									2
3	REMODELING-RESIDENT RMS, LOBBY, MAILROOM	2000	60,826	2212	27.5	2,212		2,673	3
4	PTAC UNITS	2000	4,644	169	27.5	169		204	4
5	WOOD BLINDS FOR OFFICES	2001	3,538	123	27.5	123		123	5
6	CUBICLES	2001	8,332	290	27.5	290		290	6
7	REMODEL- ALL 2ND FLOOR RESIDENT ROOMS	2001	370,353	12,907	27.5	12,907		12,907	7
8	VERTICAL BLINDS FOR 2ND FLOOR ROOMS	2001	3,847	134	27.5	134		134	8
9	CARPETING FIRST FLOOR OFFICES/PLUMBING	2001	8,850	255	27.5	255		255	9
10	DROP & CHANGE SPRINKLER HEADS IN CORRIDOR	2001	5,097	131	27.5	131		131	10
11	REPAIR CEILING ON FIRST FLOOR	2001	25,000	644	27.5	644		644	11
12	REPAIR CORRIDOR IN LAUNDRY AREA	2001	10,000	197	27.5	197		197	12
13	TEN TON COMPRESSOR FOR KITCHEN UNIT	2001	4,441	47	27.5	47		47	13
14									14
15									15
16			SL ADJ.	24,495			(24,495)		16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,470,910	$ 213,319		$ 213,319	$ 0	$ 2,282,582	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 458,935	$ 64,151	$ 45,337	$ (18,814)	3-10 YRS	$ 124,384	71
72	Current Year Purchases	42,775	8,548	4,420	(4,128)	3-10 YRS	4,420	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTIES	857,362	18,087	18,087	0		836,378	74
75	TOTALS	$ 1,359,072	$ 90,786	$ 67,844	$ (22,942)		$ 965,182	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,090,702	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 304,105	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 281,163	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (22,942)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,247,764	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 29,286 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMIN.	2000 LEXUS 400	$ 758.00	$ 11,310	17
18	FACILITY USE	99 DODGE DURANGO	625.00	7,500	18
19	MISC. USE	BUDGET VAN	1,251.00	1,251	19
20					20
21	TOTAL		$ 2,634.00	$ 20,061	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 111,807	$		$ 111,807	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,250			10,250	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			102,553			102,553	4
5	Physician Care		visits			1,672			1,672	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				183,691		183,691	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, I.V. THERAPY, RENTALS Other (specify):	39-2					102,341		102,341	13
14	TOTAL			$		$ 226,282	$ 286,032		$ 512,314	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 82,846	$ 133,390	1
2	Cash-Patient Deposits	2,258,473	2,258,473	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,955	1,955	5
6	Prepaid Insurance	35,410	184,560	6
7	Other Prepaid Expenses	4,242	4,242	7
8	Accounts Receivable (owners or related parties)	1,649,381	1,948,481	8
9	Other(specify): ESCROW DEPOSITS		42,103	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,032,307	$ 4,573,204	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		247,500	13
14	Buildings, at Historical Cost		1,849,704	14
15	Leasehold Improvements, at Historical Cost		4,491,705	15
16	Equipment, at Historical Cost	501,710	1,294,130	16
17	Accumulated Depreciation (book methods)	(320,440)	(3,449,227)	17
18	Deferred Charges	446	197,556	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		245,592	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 181,716	$ 4,876,960	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,214,023	$ 9,450,164	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 329,861	$ 451,630	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	269,548	269,548	28
29	Short-Term Notes Payable	1,415,000	1,415,000	29
30	Accrued Salaries Payable	41,872	41,872	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,050	8,050	31
32	Accrued Real Estate Taxes(Sch.IX-B)		80,724	32
33	Accrued Interest Payable	187	187	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	365,774	365,774	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,430,292	$ 2,632,785	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	19,342	193,342	39
40	Mortgage Payable		4,634,528	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 19,342	$ 4,827,870	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,449,634	$ 7,460,655	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,764,389	$ 1,989,509	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,214,023	$ 9,450,164	48

*(See instructions.)

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,058,106	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,058,110	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	706,279	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 706,279	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,764,389	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,773,987	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,773,987	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	174,756	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 174,756	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,948,743	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,162,424	31
32	Health Care	2,668,697	32
33	General Administration	2,523,033	33
	B. Capital Expense		
34	Ownership	1,253,136	34
	C. Ancillary Expense		
35	Special Cost Centers	512,314	35
36	Provider Participation Fee	118,807	36
	D. Other Expenses (specify):		
37	NET VENDING COSTS	4,053	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,242,464	40
41	**Income before Income Taxes (line 30 minus line 40)****	706,279	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 706,279	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,909	2,166	$ 90,147	$ 41.62	1
2	Assistant Director of Nursing	639	774	21,937	28.34	2
3	Registered Nurses	40,140	43,118	1,003,578	23.28	3
4	Licensed Practical Nurses	17,437	19,077	319,086	16.73	4
5	Nurse Aides & Orderlies	75,533	80,512	838,991	10.42	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,745	3,237	39,144	12.09	9
10	Activity Assistants	10,431	11,084	77,122	6.96	10
11	Social Service Workers	1,883	2,258	32,637	14.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	9,729	10,632	138,044	12.98	14
15	Cook Helpers/Assistants	11,803	12,821	83,148	6.49	15
16	Dishwashers					16
17	Maintenance Workers	3,855	4,227	57,729	13.66	17
18	Housekeepers	23,639	25,415	200,274	7.88	18
19	Laundry	11,305	12,216	89,357	7.31	19
20	Administrator	2,056	2,776	181,390	65.34	20
21	Assistant Administrator	5,832	6,219	186,747	30.03	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,338	16,112	254,123	15.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,364	2,530	26,211	10.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	235,638	255,174	$ 3,639,665 *	$ 14.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 12,684	1-3	35
36	Medical Director	42	6,000	9-3	36
37	Medical Records Consultant	13	994	10-3	37
38	Nurse Consultant	663	24,932	10-3	38
39	Pharmacist Consultant	215	3,750	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	6	286	11-3	44
45	Social Service Consultant	13	663	12-3	45
46	Other(specify) PSYCHOLOGIST	836	6,282	10-3	46
47	UTILIZATION REVIEW	53	7,950	10-3	47
48					48
49	TOTAL (lines 35 - 48)	2,033	$ 63,541		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BRIAN LEVINSON	ADMIN		$ 181,390
JUDY WONOGAS	ASST ADMIN		83,719
SID SIDDQUE	ASST ADMIN		58,194
JEREMY AMSTER	ADM IN TRAINING		44,834
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 368,137

B. Administrative - Other

Description	Amount
FIRST HEALTHCARE - MANAGEMENT FEES	$ 699,442
TOTAL (agree to Schedule V, line 17, col. 3)	$ 699,442
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		211,434
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 211,434

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,810
Unemployment Compensation Insurance	31,952
FICA Taxes	267,788
Employee Health Insurance	221,793
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	18,377
EMPLOYEE PHYSICAL EXAMS	16
PENSION/PROFIT SHARING PLANS	12,803
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 617,539

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,523
Health Care Worker Background Check	1,238
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	143,457
RELATED PARTY	2,265
CONTRIBUTIONS	6,580
DUES & SUBSCRIPTIONS	19,715
LICENSES & PERMITS	1,027
LESS: CONTRIBUTIONS	(6,580)
Less: Public Relations Expense	(76,796)
Non-allowable advertising	(56,375)
Yellow page advertising	(10,286)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,768

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,632
RELATED PARTY	12,520
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,152

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	06/98	$ 4,364	3	$ 727	$ 1,455	$ 1,455	$ 727	$	$	$	$	$
2	PAINT/DECORATING	06/2000	3,136	3			523	1,045	1,045	523			
3	PAINT/DECORATING	06/2001	2,061	3				344	687	687	343		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 9,561		$ 727	$ 1,455	$ 1,978	$ 2,116	$ 1,732	$ 1,210	$ 343	$	$

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $11323**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,883** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **118,807**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: DEERBROOK CARE CENTRE **#0040741** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	12,684	
	REPAIRS & MAINTENANCE		0	
			0	12,684
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		51	
			0	51
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		26,958	
	ELECTRICITY		89,639	
	WATER		42,854	
	CABLE TV - LOBBY		0	
			0	159,451
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,330	
	PAINTING & DECORATING		2,061	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		16,059	
	ELEVATOR MAINTENANCE & REPAIR		4,906	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,012	
	FIRE SERVICE		1,819	
	DEFERRED MAINTENANCE		2,225	
			0	
			0	35,412
7	**OTHER**			
	SCAVENGER		9,337	
	SECURITY SERVICE		0	9,337
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	994	
	PHARMACY CONSULTANT	XVIII B 39-2	3,750	
	UTILIZATION REVIEW FEES	XVIII B 47-2	7,950	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	24,932	
	PSYCHOLOGIST	XVIII B 46-2	6,282	
			0	43,908
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	286	
			0	286
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	663	
			0	663
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DEERBROOK CARE CENTRE **#0040741** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		530	530
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	699,442	699,442
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	25,723	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	185,711	
			0	211,434
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	76,796	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	56,375	
	EMPLOYEE WANT ADS	XIX F	14,523	
	CONTRIBUTIONS	VI 20 XIX F	1,275	
	DUES & SUBSCRIPTIONS	XIX F	19,715	
	LICENSES & PERMITS	XIX F	1,027	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	10,286	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,305	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,238	186,540
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		358	
	EQUIPMENT REPAIR & MAINTENANCE		7,289	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	197	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		54	
	TELEPHONE		43,552	
	MESSENGER SERVICE		486	
			0	51,936

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	267,788	
	UNEMPLOYMENT COMPENSATION	XIX D	31,952	
	WORKERS COMPENSATION INSURANC	XIX D	64,810	
	HOSPITALIZATION INSURANCE	XIX D	221,793	
	EMPLOYEE BENEFITS - OTHER	XIX D	18,377	
	EMPLOYEE PHYSICAL EXAMS	XIX D	16	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	12,803	
	CHICAGO HEAD TAX	XIX D	0	617,539
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		9,524	9,524
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	1,632	
			0	
			0	1,632
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,411	8,411
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		15,499	15,499
27	**OTHER**			
	BAD DEBTS	VI 24	47,053	
			0	47,053

GRAND TOTAL COLUMN 3 OTHER 2,117,332

DEERBROOK CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	239,822	PATIENT MEALS	192618
LESS SALES TAX	(1,933)	ADD EMPLOYEE MEALS	0
NET FOOD	241755	TOTAL MEALS/YEAR	192618
TOTAL PATIENT CENSUS	64,206	NET FOOD	241755
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	192618
TOTAL PATIENT MEALS	192618	COST PER MEAL	1.26
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

DEERBROOK CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2001

INCOME PER F/S									8,230,705	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	2,668,697	617,539	547,377	117,233	497,814	1,905,494	118,807	1,253,136		3,639,665
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	6,130		11,403			31,814		(49,347)		
CABLE TV			0			0				
CONTRACT NURSING										
INTEREST INCOME							(174,756)			
NET VENDING COMMISSIONS							4,053			
EMPLOYEE PHYSICAL EXAMS		(16)				16				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(699,442)		699,442		
RESIDENT TAX REBILLED - PVT										
BAD DEBTS						(47,053)	47,053			
DISCOUNTS LOST							0			
AMORT-COMP SOFTWARE								0		
SETTLEMENT INTEREST										
RECLASSED SALARIES	(24,034)	0	0	0	0	24,034	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	(30,968)	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	2,650,793	617,523	558,780	117,233	497,814	1,214,863	(35,811)	1,903,231	7,524,426	3,639,665
PER FINANCIAL STATEMENTS	2,650,793	617,523	558,780	117,233	497,814	1,214,863	(35,811)	1,903,231	706,279	3,639,665
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									706,279	

DEERBROOK CARE CENTRE - COMPARISONS - 12/31/2001

	ref.	12/31/2001			12/31/2000			DIFF	12/31/1999		
CAPACITY DAYS		79,205			79422			(217)	79205		
CENSUS DAYS		64,206			66900			(2,694)	64146		
OCCUPANCY %		81.06%			84.23%				80.99%		
SALARIES											
TOTAL General Services	8-1	568,552	7.87%	8.86	546511	8.24%	8.17	22,041	634898	10.07%	9.90
Social Services	12-1	32,637	0.45%	0.51	54369	0.82%	0.81	(21,732)	29055	0.46%	0.45
TOTAL Health Care and Programs	16-1	2,448,853	33.91%	38.14	2272372	34.25%	33.97	176,481	2154651	34.19%	33.59
Clerical & General Office Expenses	21-1	254,123	3.52%	3.96	197802	2.98%	2.96	56,321	232479	3.69%	3.62
TOTAL General Administration	28-1	622,260	8.62%	9.69	516251	7.78%	7.72	106,009	496080	7.87%	7.73
TOTAL Operation Expense	29-1	3,639,665	50.41%	56.69	3335134	50.27%	49.85	304,531	3285629	52.13%	51.22
ADJUSTED TOTALS											
Food	2-8	237,889	3.29%	3.71	206693	3.12%	3.09	31,196	192586	3.06%	3.00
Heat and Other Utilities	5-8	159,451	2.21%	2.48	156105	2.35%	2.33	3,346	154857	2.46%	2.41
Maintenance	6-8	138,551	1.92%	2.16	152926	2.31%	2.29	(14,375)	143357	2.27%	2.23
TOTAL General Services	8-8	1,158,017	16.04%	18.04	1167099	17.59%	17.45	(9,082)	1207958	19.17%	18.83
Administrative	17-8	392,651	5.44%	6.12	332136	5.01%	4.96	60,515	280433	4.45%	4.37
Directors Fees	18-8	0	0.00%	0.00				0			
Professional Services	19-8	222,132	3.08%	3.46	290797	4.38%	4.35	(68,665)	195929	3.11%	3.05
Fees, Subscriptions, Promotions	20-8	38,768	0.54%	0.60	24608	0.37%	0.37	14,160	29377	0.47%	0.46
License Fee-IDPA	Pg21	0	0.00%	0.00	200	0.00%	0.00	(200)	200	0.00%	0.00
License Fee-Other	Pg21	1,027	0.01%	0.02	597	0.01%	0.01	430	1088	0.02%	0.02
Clerical & General Office Expenses	21-8	492,781	6.82%	7.67	410955	6.19%	6.14	81,826	429403	6.81%	6.69
Employee Benefits & Payroll Taxes	22-8	617,539	8.55%	9.62	516895	7.79%	7.73	100,644	661850	10.50%	10.32
Payroll Taxes	Pg21	299,740	4.15%	4.67	289627	4.37%	4.33	10,113	312890	4.96%	4.88
W/C Insurance	Pg21	64,810	0.90%	1.01	49387	0.74%	0.74	15,423	100813	1.60%	1.57
Health Insurance	Pg21	221,793	3.07%	3.45	135785	2.05%	2.03	86,008	217345	3.45%	3.39
Inservice Training & Education	23-8	9,524	0.13%	0.15	10884	0.16%	0.16	(1,360)	11914	0.19%	0.19
Travel and Seminar	24-8	14,152	0.20%	0.22	14275	0.22%	0.21	(123)	10124	0.16%	0.16
Other Admin. Staff Transportation	25-8	8,411	0.12%	0.13	5641	0.09%	0.08	2,770	6822	0.11%	0.11
Insurance-Prop.Liab.Malpractice	26-8	180,782	2.50%	2.82	145294	2.19%	2.17	35,488	91777	1.46%	1.43
Other (specify):*	27-8	0	0.00%	0.00				0			
TOTAL General Administration	28-8	1,976,740	27.38%	30.79	1751485	26.40%	26.18	225,255	1717629	27.25%	26.78
TOTAL Operation Expense	29-8	5,809,841	80.46%	90.49	5335943	80.43%	79.76	473,898	5216405	82.77%	81.32
Real Estate Taxes	33-3	83,807	1.16%	1.31	79514	1.20%	1.19	4,293	72616	1.15%	1.13
Real Estate Legal	Pg10	0	0.00%	0.00				0			
GRAND TOTAL COST	45-8	7,220,628	100.00%	**112.46**	6634016	100.00%	**99.16**	586,612	6302323	100.00%	**98.25**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		2719262.1	37.66%	**42.35**	2566401	38.69%	**38.36**	152,861	2491559	39.53%	**38.84**

DEERBROOK CARE CENTRE - DIAGNOSTICS - 12/31/2001

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 2116 from Page 22 and -2061 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-346587
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 DOES NOT EQUAL Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-231406
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.